Patient Tracking Form for Swing Bed Admission

Patient:_____

Anticipated Date of Admission:_____

Reason for Admission:_____

Insurance:_____

Number of Skilled (Swing) Days Available in Benefit Period:_____

Dates of Acute Hospitalization:_____

Transferring Physician Name:_____

Accepting Physician Name:_____

Case Manager/Nursing Supervisor:_____

Contact Person at Transferring Hospital:_____

Patient Transfer Form to Critical Access Hospital

Patient Name_____DOB_____

Transfer From_____
Date_____ Time_____
Transfer To_____

Dates of Stay _____ _____
Admitted Discharge
Physician_____ Phone_____
Will Follow Yes__ No__
Contact Person_____ Phone_____
Reason for Transfer_____
_____
_____
_____
_____

Diagnosis:
(1)_____ (2)_____

PATIENT CHARACTERISTICS:
Height:_____ Weight:_____
B/P:_____ Temp:_____
Pulse:_____ Resp:_____
Incontinence: Bladder Yes__ No__
Bowel Yes__ No__
Date of Last B.M._____
Fall Risk: Low____ Moderate____ High____
Aspiration Risk: Low___ Moderate___ High___
Skin Status: Rash:_____ Excoriations:_____
Pressure Ulcers:_____ Stasis Ulcers:_____
Bruises_____ Location_____
Wounds _____

Pain Scale_____
Allergies_____
Diet Order_____
Psychosocial Info_____
Additional Comments_____
_____
_____
_____

Required Transfer Documents
ATTACH:
Face Sheet _____
H&P _____
Advanced Directives _____
Labs/X-Ray Reports _____
Physician Orders _____
Medication/Treatments _____
Discharge Notes _____
All Progress Notes _____
Copy of Chart Preferred

SENSORY/LANGUAGE

Sight	Hearing	Communication
__Adequate	__Aid R/L	__Speaks Well
__Glasses	__Hard of Hearing	__Non Verbal
__Contacts	__Partially Deaf	__Aphasic
__Blind R/L	__Totally Deaf	__Garbled
		__Can Read/Write
Primary Language_____		__Sign

MENTAL STATUS:	Current	Baseline
Alert	_____	_____
Confused	_____	_____
Strikes Out	_____	_____
Oriented	_____	_____
Depressed	_____	_____
Comatose	_____	_____
Forgetful	_____	_____
Withdrawn	_____	_____
Noisy	_____	_____
Wanderer	_____	_____
Climbs Out of Bed	_____	_____
Other	_____	_____

APPLIANCES/PROSTHESES Sent=S Needed=N
Cane_____ Contact Lens_____
Dentures U/L_____ Glasses_____
Prosthesis _____(type) _____
Crutches_____ Wheelchair_____
Walker_____ Other_____
Restraints (Kind) _____

FUNCTIONAL LEVELS:

	Independent	Needs Assistance	Dependent
Bed Activity	_____	_____	_____
Personal Hygiene	_____	_____	_____
Dressing	_____	_____	_____
Eating	_____	_____	_____
Transfer	_____	_____	_____
Locomotion	_____	_____	_____
Weight Bearing	_____	_____	_____
Rehab Potential	_____	_____	_____
Activity Tolerance	_____	_____	_____

Name of Person Completing Report Phone
_____
Called To:_____ Phone:_____
Faxed To:_____ No.:_____